

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/02/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G257		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 06/28/2012	
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST				STREET ADDRESS, CITY, STATE, ZIP CODE 2524 BEECHWOOD CIR FORT WAYNE, IN 46807			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	<p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey conducted on 05/11/12 was conducted by the Indiana State Department of Health in accordance with 42 CFR Subpart 483.470(j).</p> <p>Survey Date: 06/28/18</p> <p>Facility Number: 000777 Provider Number: 15G257 AIM Number: 100243390</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this PSR survey, Easter Seals ARC of Northeast Indiana Inc. was found in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) Chapter 33, Existing Residential Board and Care Occupancies</p> <p>This two story facility with a basement was not sprinklered. The facility has a fire alarm system with smoke detection on all levels including in the corridors and common living areas. The facility has a capacity of 5 and had a census of 5 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6 rated the facility Prompt with an E-score of 1.1.</p> <p>Quality Review by Robert Booher, Life Safety</p>			{K 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/02/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G257		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 06/28/2012	
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST				STREET ADDRESS, CITY, STATE, ZIP CODE 2524 BEECHWOOD CIR FORT WAYNE, IN 46807			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	Continued From page 1 Code Specialist-Medical Surveyor on 06/29/12.			{K 000}			